

## **CLARK COUNTY HEALTH DEPARTMENT**

P.O. Box 9825 • 2000 Fort Vancouver Way • Vancouver, WA 98666-8825 (360) 397-8215 • Fax (360) 397-8402

## **AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Name:	DOI	B:	Phone #	<i>‡</i> :
PLEASE <u>OBTAIN</u> INFORMATION <u>FROM</u> :	ľ	PLEASE <u>SEND</u> INF	ORMATION :	<u>ΓΟ</u> :
Name of Provider/Clinic/Organization	Ī	Name of Provider/Clinic/Organization		
Street Address	. (	Street Address		
City, State, Zip Code		City, State, Zip Code		
Phone: FAX:		Phone:	FAX	K:
I AUTHORIZE the following information to be disclosed:	(Please	initial all that apply)		
Immunization Record S	_ HIV Record _ STD Record Psychiatric/Mental Health			Billing Records Other
	,	Substance Use		Date(s)
REASON for disclosure of health information: (Please ini	<u>itial</u> )			
Continuing Care	Job School Insurance	e		Other
EXPIRATION of this Authorization: (Please initial one)				
90 days after signature date0 When this event happens:	On this d	ate:		
ADDITIONAL PATIENT INFORMATION:				
<ul> <li>I understand that I have the right to withdraw</li> <li>I understand that I do not have to sign this au</li> <li>I understand that once my health care inform recipient and is no longer protected by Clark</li> <li>I understand that signing this authorization do</li> </ul>	uthorization nation is c County.	ion to get treatment. disclosed as I have a	authorized, it o	could be redisclosed by the
Client Signature (Parent or Legal Representative, if applicable)		- L-tianahin/Authoritu	Date:	
	Re	elationship/Authority	5.4	
*I wish to withdraw this authorization:			Date:	
□ Pick-Up Records □ Mail Records □ FAX Records		ame:	First	MI
HR-08 Rev. 03/2003 File under: CORRESPONDENCE Distribution: White – Record Yellow - Client		OB: MM/DD/YYYY RN:		Sex: □ F □ M

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